Centre for Integrative Care Stakeholder Reference Group

Tuesday 27th September 2016
10am – 12pm
Meeting Room F, JB Russell House

Draft Minutes of Meeting

Present:

Gary Jenkins (Chair)	Director Regional Services, NHSGGC
Barry Sillers	Head of Planning, Regional Services, NHSGGC
Bill Cameron	Patient Representative, Long Term Conditions MCN
Cath Cooney	House of Care Manager, The Alliance
John Duffy	Patient Representative, Acute Division Patient Panel
Julia Little	General Manager, Centre for Integrative Care, NHSGGC
Lorna Gray	Patient Experience, Public Involvement Project Manager, NHSGGC
Louise Wheeler	Scottish Health Council
Rona Agnew	Chair, Friends of the Centre for Integrative Care

Actions

1. Welcome & Introductions

Gary Jenkins welcomed everyone to the meeting and introductions were made around the table.

Gary then set out the content of the day and what would be covered at this first meeting including:

- The purpose of the Stakeholder Reference Group and Terms of Reference
- A presentation on the proposal on how services could be delivered in the future along with information on the current demand and referral patterns to the service
- The ways in which we intend to inform and engage with stakeholders.

2. Draft Terms of Reference and Group Remit

Lorna talked to the draft terms of reference for the group, which had already been sent in advance.

Specifically discussed was the role of the group as a support and guide to NHSGGC through the engagement process, providing advice on what information we need to put out, to whom and in what way. It was suggested that the group meets twice, this first meeting and towards the end of the engagement period, however if felt that more meetings would be beneficial they can be added in.

Lorna talked through the membership of the group, and in particular those who had been invited to attend but who had not been able to attend this first meeting. The group was also advised that there is a separate Patient Panel which will link with the SRG, and is made up of current patients of the Centre for Integrative Care (CIC). The group were asked to comment on whether they felt that the membership was appropriate, or whether there were others they felt would be beneficial to have on the group.

It was suggested that GP representation would be helpful, maybe the highest referrer to the CIC, and one of the lowest referrers. Lorna will get in touch with these GPs to see if they would be interested in joining the group. **Lorna**

Louise asked about representation from current patients on this group in particular. It was explained that the Patient Panel was set up with a similar remit to this group, but specifically to allow more patients to contribute to how the engagement will be carried out. Louise suggested that a member of that Panel also sits on the SRG for continuity, however Lorna suggested that we discuss more how the information is shared between the two groups instead, to ensure there is clarity and consistency of information between the two.

There were no further suggestions or comments on the Terms of Reference.

3. Overview of Proposed Service Change

Gary presented on the proposed service change, including what would potentially change; what wouldn't change; what the service currently looks like; and examples of other services that deliver care in similar ways to what is being suggested for the CIC. The presentation will be sent out to all members. **Lorna**

Gary encouraged members to ask questions as he went through the presentation. The main points of discussion were as follows:

- Looking at inpatient/ outpatient numbers per Health Board, Cath asked whether the uptake had changed at all since the change from a 7 day service to a 5 day service. Gary and Julia will look to see if this data is available. **Gary/ Julia**

- Gary presented a table showing what the inpatient programme consisted of, including the therapies/ group sessions etc that patients attend while staying as an inpatient. Rona asked him to confirm what else was provided – Julia advised that this is the basic programme, some patients do less, some have additional treatments (e.g. acupuncture) but this is the basic programme that all inpatients follow. She also advised that patients use the time in between as rest between therapies.

- Rona felt that this table didn't reflect the additional support received by patients, in particular the non-therapy elements in which nursing staff can talk in depth with the patients and help them in dealing with the psychological/ emotional impact of their illness and providing support in this. Rona felt this qualitative, holistic approach was missing from

the information presented about what the inpatient programme involves. Gary said that he had been informed by the service that patients may open up to staff during rest periods overnight.

- The process for becoming an inpatient was discussed, with Julia advising that patients are referred to the CIC by a GP or other referrers and have an initial Integrative Care Assessment at an outpatient consultation to decide what treatment therapies the patient would most benefit from. A clinician would also decide whether they felt a patient would benefit from taking part in the inpatient programme.

- Cath advised that the Alliance were not entirely clear on the reasons for the proposal, i.e. whether this was about efficiency or other. Gary advised that the CIC, and all other health services, continually review how they are delivering care to ensure they remain fit for purpose. This proposal is part of that recognition. Cath agreed that the CIC does need refreshing and welcomed the fact that the Patient Panel and SRG would be able input to that. She felt that the Alliance wouldn't necessarily discount the ambulatory model as a way to refresh, but to start with this may be a missed opportunity. Cath also asked whether there is the opportunity to integrate/ co-locate the CIC with other services, utilising the person-centred, holistic skills of the staff.

- Rona agreed that more time should be taken to look at Integrative Care as a whole and how this should be provided throughout health services. There was discussion around whether there was the opportunity to pause this process to consider the integration of integrative care more widely. It was agreed that this was out with the remit of this group, and that we are currently in a period of engagement, with the role of this group (as set out in the terms of reference) to assist in ensuring the right information goes to the right people. There is no opportunity to pause the process, however the suggestions, comments and questions being asked here will be considered in terms of the information we provide more widely. Gary stated that an international conference held in Stuttgard had focussed on how Integrative Medicine could become more mainstream in the context of supporting 'traditional' medicine.

- Gary went on to show more detail around the numbers of inpatients, including the Health Boards referred from and for the Glasgow and Clyde patients, where they live. There was discussion around the arrangements with other Boards re referrals, as other Boards have recently made other arrangements around this.

- The diagram around distribution of patients from GGC showed that the majority lived in the West Glasgow area. Rona felt this information was a bit of a red herring, given that other Boards aren't referring, therefore it is clear that Glasgow will have the highest numbers. Gary advised that this was specifically to look at the distribution in Glasgow, but we will add into information about other Board's referrals in order to be transparent about this.

- The distribution around Glasgow also showed that most of the referrals came from the least deprived areas of Glasgow. It was questioned whether this pointed to an unmet need in the more deprived population, or what other services are those communities accessing instead? This is similar in places such as Lothian where there are no longer referrals – what other services are those populations accessing. This is part of the bigger picture and not necessarily about this particular proposal.

- There was discussion around whether the referrals in Glasgow have changed since the decision by other Boards to pull out of referrals – Julia will have a look at the data and send out if helpful. **Julia**

- The previous change to the number of beds and nights available for patients was raised again. Julia advised that this was a result of a previous redesign, guided by the Long Term Conditions Collaborative workplan at Scottish Government. The last redesign was 2010/11, and there have already been discussions between the clinical team and other members of staff about needing to look again at how they are delivering the services and different ways to do this. These conversations started a year ago, however no work is taking place at the moment to allow this engagement process to come to an end, and redesign will be based on the outcome of that process.

- Bill asked whether it would be plausible that the staff and structure of the CIC could shift to more of an outreach model. Julia advised this was something that hadn't been considered before, but felt it was an excellent idea that should be explored.

- Costs of the service were discussed, with the projected savings from the proposal being approximately £190,000. The relatively small sum is because the vast majority of the services would stay exactly the same, and it would only be the overnight element that would change. It was confirmed that there are no resident doctors in the CIC at night, and a couple of nurses on duty. There are no medical interventions in the CIC overnight, and if someone falls acutely ill while in the CIC, medical cover would be provided from the neighbouring Gartnavel General.

- John suggested that it appears the beds simply provide overnight 'hotel' services, and although relatively small sums, there is still a need to justify how and where we are spending public money.

- Gary showed examples of different services who use a similar model to that being proposed for the CIC. This included the two other centres for integrative care in London and Bristol, both of whom offer an ambulatory service with no overnight beds for patients. Gary and Julia have both tried to make contact with these hospitals to understand the impact and outcomes for patients when this change was made and although have had no information as yet, will continue to try to get this information so as to provide the group with some examples of similar models.

- Gary also used the Beatson as another example of a service which is moving to a more day-case model of treatment for patients, using a graph to demonstrate the trend of increased day case and decreased inpatient care since 2010. He provided the example of patients being treated for prostate cancer who travel to the Beatson for treatment daily, returning home each day. He also advised that the kind of psychological, psychiatric or emotional support that was discussed earlier as an important part of the CIC's work is built into the treatment plan for patients having cancer treatment and therefore this could similarly be done for day patients at the CIC. There is a need to consider whether the nurses at the CIC are best placed to deal with the emotional impact of people's illnesses and whether a more planned model of this support would be more beneficial.

- Gary advised he would be happy to look at different models with this group and that could be done at the next meeting. This could be informed by the intelligence received from the other Integrative Care Services in the UK.

- This led to discussion about general integration of integrative care services which is was agreed that would be part of a bigger debate, but particularly there could be clear links/ input from psychiatry/ mental health services. It was also clear that there were synergies between the CIC and Chronic Pain services, in both the services and patient groups. It was agreed that being a stand-alone unit doesn't necessarily do any favours for the CIC, and therefore integration with other services is hugely important.

- John asked what staff are thinking about other ways to do things, referring to the fact that some of these conversations have already started. John asked that the thoughts of the staff are shared as well.

- John suggested that a travel element needs to be included in the process, particularly considering the costs of this which may be a barrier for some people.

- Rona felt that while not necessarily against the ambulatory care model, strong consideration needs to be given to whether this is actually the best thing to do for the service, as well as looking fully at the long term affect on the patients of closing the beds.

4. Draft Involvement and Communications Plan

Lorna spoke to the draft involvement and communications plan which had been sent out to members in advance.

Because of the time taken to have a full and meaningful discussion about the proposal, there was limited time to talk through the involvement and communications plan in full. Members however had already had the opportunity to read the plan and Lorna asked if they had any initial thoughts to share just now. There were no comments at this stage, but Lorna suggested that they have another read and this would be picked up by email and again at the next meeting of the group.

The draft text of a leaflet was also to be tabled, and Lorna suggested that **Lorna**

this could be sent by email, once some amendments were made based on some of the discussions had here today.

The group agreed they were comfortable with this approach.

5. AOCB

It was agreed that another meeting would be scheduled for 4 weeks time. Gary and Julia will aim to have examples of models of other Integrative Care Centres to share by then. **Gary/ Julia**

Julia will provide a list of the staffing complement at the CIC. **Julia**

John asked whether a visit to the CIC could be arranged. Lorna will look into this, perhaps using the CIC as the venue for the next meeting. **Lorna**

9. Date of Next Meeting

To be confirmed.